



OMIG reform
A.7448-A Schimminger/S.4218-A Stachowski
SUPPORT

SUMMARY: Section 1 amends Article 1, Title III of the Public Health Law by adding a new section 32-A that prohibits withholding of Medicaid provider payments based on **preliminary** findings of a pending audit unless the OMIG has issued a written finding of probable cause that the provider committed fraud or another crime.

JUSTIFICATION: Medicaid providers have been the subject of intense audits by the Office of the Medicaid Inspector General (OMIG) and contingency-based auditing firms. Legitimate providers in large numbers report that audit findings of administrative errors in claims submission or omissions in documentation have formed the basis of very substantial monetary penalties (calculated through the use of extrapolation) in hundreds of thousands, even millions of dollars. The bill addresses their concern that even **before** due process procedures are completed, OMIG has the authority to begin recovery efforts by withholding payment in non-fraud cases. OMIG has, in fact, exercised the authority to withhold or has threatened to withhold payment as the means to force providers to waive their right to an administrative hearing and agree quickly to pay a substantial monetary penalty calculated through extrapolation. This bill would prohibit OMIG from withholding payments from providers who are under no suspicion or accusation of fraud until the audit is final and the provider's rights to appeal an audit result are exhausted. This bill would resolve the most egregious practice of OMIG. It is reasonable, fair and overdue.

While the OMIG's efforts to identify and punish real Medicaid provider fraud and abuse are very important, seizing on honest mistakes or software glitches to extrapolate excessive monetary penalties and then threatening business-closing withhold amounts is not only unfair, but also potentially damaging to the Medicaid program itself.



Medicaid Pharmacy Reimbursement Study
A.8782-A Destito/Valesky
SUPPORT

SUMMARY: Section one of the bill creates a workgroup within the Department of Health to assist the Commissioner of Health in studying Medicaid prescription drug reimbursement to retail pharmacies. Section two outlines the different factors to be considered in the study. Section three requires the Commissioner of Health to issue a report to the Governor and the Legislature.

JUSTIFICATION: It has become important for the legislature to have access to factual information on which to base policy and budget decisions with regard to payments to pharmacies. This legislation requires the Health Department, working with representatives of organized pharmacy and other stakeholders, to gather information and prepare a report to inform about the adequacy of present reimbursement in terms of actual costs both for medications and professional services.

Compounding the pharmacy reimbursement matter further is the

use of the term 'Average Wholesale Price' (AWP) that, combined with a discount, forms the payment formula for brand drugs. For generics, New York State law allows the Department of Health to calculate 'State Maximum Allowable Cost' (SMAC). Pharmacies report that SMAC pricing is not based on any known methodology and it brings payment levels unrealistically low in many cases. Access to generics is an important cost-containment strategy, and legislators should have confidence that the state's reimbursement policy is set appropriately.

As enumerated in this legislation, pharmacy overhead costs cover a wide range of elements that should be considered as factors in a fair and reasonable payment standard. For the consumer, the professional service components may represent the real value of having a local pharmacy with an accessible pharmacist who has filled the prescription, checked for drug interactions and can convey important individualized information based on the medications that have been prescribed. In this time of limited resources, it becomes more important that our Medicaid and EPIC beneficiaries derive the maximum therapeutic benefit from their medicines so that they can remain at home living independently as long as possible. Local pharmacies represent healthcare outreach into communities and as such also represent a valuable cost-containment strategy.



Mandatory Medicaid Reimbursement Study Bill
S.1067 Kruger (No Same As)
SUPPORT

SUMMARY: This bill creates a sixteen-member temporary state commission to study Medicaid reimbursement formulas and dispensing fees in this state and in contiguous and comparable other states as well as the average costs involved in the operation and management of pharmacies and the potential cost-savings related to the Medicaid prescription drug program. The bill sets forth the powers and duties of the commission.

JUSTIFICATION: The health needs of New York's indigent residents demand that our Medicaid program provides ready access to medications. To do so we must examine the ways to improve the efficiency of the drug reimbursement program and the services provided to its recipients, as well as to make sure the program recognizes the importance of participating pharmacists and the need to provide them with monetary compensation necessary to maintain their businesses.

As a result of the First Data Bank settlement of September 26, 2009, Average Wholesale Price (AWP) will no longer be available as a reimbursement benchmark for pharmacies, making the current state law obsolete in 2010 or early in 2011. It is therefore essential that a new reimbursement mechanism be examined and wholly appropriate that a Commission be created to evaluate the reliability of Wholesaler Acquisition Cost (WAC) as the basis for the new pharmacy payment system.



Medicaid Formula Change
from AWP Minus to WAC Plus
A.9139-A Destito/S.6146-A Klein
SUPPORT

SUMMARY: Section 1 of the bill amends social services law to change the reimbursement methodology used to reimburse pharmacies for brand-name drugs under the State Medicaid program from Average Wholesale Price (AWP) minus 16.25% to its equivalent, Wholesale Acquisition Cost (WAC) plus 4.68%. This change would also apply to Family Health Plus, Child Health Plus and the AIDS Drug Assistance Program (ADAP) because the pharmacy reimbursement rates under these programs are the same as Medicaid rates.

Sections 2 and 3 of the bill amend elder law to change the reimbursement methodology used to reimburse pharmacies for brand-name drugs under the Elderly Pharmaceutical Insurance Coverage Program (EPIC) from AWP-16.25% to its equivalent, WAC plus 4.68%.

JUSTIFICATION: Under current law, pharmacies are reimbursed for brand name drugs in public programs using the benchmark Average Wholesale Price (AWP) minus a percentage. Settlement in a federal court case in which pharmacies were not a party reduced the value of Average Wholesale Price on September 26, 2009 and also required that AWP will no longer be available as a reference price for the purpose of pharmacy reimbursement, effective sometime in 2010 or 2011. It is therefore incumbent on the state to establish a new reimbursement methodology for brand-name prescription drugs. This bill introduces the new payment methodology based on Wholesaler Acquisition Cost (WAC) that is considered by the Congressional Budget Office as a better, more transparent pricing benchmark.

This legislation preserves the pharmacy payment level that was adopted in the SFY 2009-2010 budget by converting AWP minus 16.25% to WAC plus 4.68% which is its mathematical equivalent. The conversion is necessary because the **value** of AWP dropped by four basis points on September 26, 2009, thereby reducing the amount the state has been paying pharmacies since then. For many pharmacies this mid-year drop in payments represents a watershed event because their inventory costs did **not** drop at all. Product costs were not affected by the federal case.

This legislation is necessary to reverse the steepest drop in pharmacy payments in history that occurred on September 26, 2009, a cut that was not approved by the legislature. By maintaining pharmacy reimbursement at the levels approved in the SFY 2008-2009 state budget, this legislation seeks to preserve a very low reimbursement rate, in fact the lowest pharmacy payment rate in the nation. The bill addresses a concern that this level of payment is necessary to preserve a network of participating pharmacies throughout the state, a network that could be at risk of failing if or when pharmacy reimbursement falls too low. In that case, other medical costs would increase. The products and services routinely provided by pharmacies are essential in the state's efforts to control health care spending by maintaining New Yorkers in their homes and communities, avoiding more costly care in hospitals, clinics and emergency rooms.

Almost a dozen other states and many private insurers have adopted WAC-plus-a-percentage as a reimbursement methodology.



PBM Transparency
A.2008-A Gottfried/S.3930 Duane
SUPPORT

SUMMARY: Section 1 of the bill defines pharmacy benefit management and establishes accountability and transparency in the pharmacy benefit managers' contractual relationships with health plans. The legislation establishes that prescription benefit managers (PBMs) have a **fiduciary** responsibility to the purchasers of their management services who are insurance companies, employers or government entities.

Section 2 provides for severability. Section 3 states that the bill would take effect within ninety days of becoming law and would not affect established contracts until they expire.

JUSTIFICATION: Placing this statement into law is significant because it would require PBMs to act not in the best interest of themselves, as they do today, but rather in the best interest of the groups or businesses who pay them. From recent experiences as well as ongoing court cases in this arena, it is clear that passage of this bill will bring clarity into contracting for prescription benefits and will bring significant savings to every purchaser of prescription drug benefits including employers, unions, cities and the state itself by shedding light on information that is now unavailable. The bill is modeled after a Maine statute that has survived court challenge.

PBMs are middlemen who are unregulated by federal or state law. They are neither insurers nor providers of services, yet they determine which prescription drugs will be 'preferred' and which will be 'non-preferred'. The basis of these determinations can be shrouded in secrecy. 'Preferred' drugs are readily accessible to consumers because their co-payments are low and they can be prescribed more easily without 'prior approval'. 'Non-Preferred' products require 'prior authorization' and have higher co-payments. These strategies that drive the market share of particular medications also raise rebate revenues for the PBM that the PBM shares in some proportion with its clients. PBM's consider rebate information 'proprietary.'

PBMs also determine networks of providers, in other words, which pharmacies are 'in' and which are 'out'. Some pharmacies are never offered a contract to participate. Because pharmacies enter into contracts with PBM's, it is important to note that it is the PBM that establishes the terms of the contract that include how the pharmacy will be paid and when. Independent pharmacies report that the PBM contracts are non-negotiable. Also, since these contracts with the provider network are proprietary, the health plans, unions or businesses that hire the PBM to manage the prescription benefit do not know how much participating pharmacies are paid. In fact, court documents reveal that plans are always charged more than the pharmacy is paid. Sometimes the plan is charged a multiple of what the pharmacy is paid. Clearly, PBM 'transparency' would introduce significant amounts of new information into the business relationship with payors and in so doing would lead to significant cost savings across the board.

The Centers for Medicaid and Medicare Services have approved the use of WAC, a published price for brand-name prescription drugs and a credible alternative to a methodology soon to be obsolete.

2010 Legislative Priorities



Pharmacy Healthcare Gamble in New York State

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While this legislation does not establish any contract terms, it does require Prescription Benefit Managers to fully disclose to the payor what rebates are received in connection with their benefit package and how much the network pharmacies are paid. Under this legislation, PBMs would also be required to divulge what they pay their subsidiary mail order pharmacies.

As a matter of sound public policy, this legislation will allow private insurers and public payors to better understand the prescription benefit they are providing to their employees and enrollees. It will shed light on information that is now hidden from them. Because payors will have greater access to information, they will become more prudent purchasers and achieve the result they seek that is to reduce the cost of providing a prescription benefit while maintaining good access and high service quality. This bill is an effective instrument for controlling cost of the prescription **benefit** thereby reducing overall healthcare costs.



Medicaid Fee Increase A.1118-B Destito/S.3901-B Addabbo SUPPORT

SUMMARY: The bill amends elder law and social services law with regard to the dispensing fee paid to retail pharmacies in the Medicaid and EPIC programs; it includes a higher fee for pharmacies providing prescription drugs in special packaging for use in nursing homes and other residential care establishments.

JUSTIFICATION: Increasing the dispensing fees in state-administered pharmacy programs is long overdue. The current dispensing fees of \$3.50 for a brand-name prescription and \$4.50 for a generic are below the actual cost of dispensing as reported in national surveys. The enacted 2008-2009 state budget reduced the amount paid to cover the cost of the medication without a counterbalancing increase in the dispensing fee. Other states with similar low levels of product reimbursement such as California have higher dispensing fees in order to meet the "reasonableness" standard in federal statutes that govern Medicaid programs.

The actual cost of dispensing a prescription to a beneficiary in the New York Medicaid program ranges between \$8.79 and \$14.04 according to the survey conducted by Grant Thornton released in January, 2007. Although the dispensing fees in this legislation are below these amounts, they are consistent with reimbursement policies that are in place in other states.

The most drastic pharmacy cut in history was enacted on July 1, 2008, as part of the state's 2008-2009 budget, reducing payment levels for both brands and generics. On September 26, 2009, reimbursement for brands fell by an additional four basis points when a federal court settlement reduced the value of the AWP benchmark. Pharmacy reimbursement has two components: a product cost allowance and a dispensing fee. On the product side, over the past fourteen years the state has steadily reduced payments for both brands and generics. Although the legislature has actively resisted the cuts proposed by the Executive in virtually every state budget and has restored millions in the proposed cuts, pharmacy reimbursement has been cut twelve times. Today the state pays less for brands than any other Medicaid program and for generics the payment is lower than the level established by CMS, and lower than payment amounts in other states. These reductions in payment to pharmacies have occurred at the very same time that

inventory costs have gone up. In these years, the state has realized significant annual increases in pharmaceutical manufacturer rebates. Improving the professional fee structure is not only reasonable, it is also long overdue, given the cost-effective value of the services that pharmacists provide and the cost-benefits of the medications themselves in controlling both chronic and acute medical conditions.

Another aspect of the public programs in New York are the co-payments of \$1 (generics) and \$3 (brands) in Medicaid and the current \$6 in Family Health Plus. The co-payments are not mandatory and frequently are not paid. The state automatically deducts the co-pay from pharmacy payments, making the proposed dispensing fees in this bill even more modest and reducing the current fees actually paid to \$.50 brands and \$3.50 generics. When the fees were adjusted in 1994, they were offset by a change on the product side. The last increase in pharmacy reimbursement occurred in 1976.



Collaborative Drug Therapy Management A.6848 Canestrari/S.3292 LaValle SUPPORT

SUMMARY: Section 1 of the bill expands the definition of the Scope of Practice of Pharmacy to include medication review and collaborative drug therapy management (CDTM). CDTM is defined as a written agreement with a physician or nurse practitioner to manage patients with a defined disease. The pharmacist would be authorized in the specific agreement to adjust the drug dosage, frequency or route of administration, order clinical laboratory tests and monitor the patient. This expansion of authority for the pharmacist is limited to nursing homes, hospitals, hospital-based out-patient department and up to seven community pharmacy practice sites chosen by the education department to participate in a demonstration project.

JUSTIFICATION: Adverse drug reactions (ADR's) or adverse drug events (ADE's) are now reported to be the fourth leading cause of death in the United States, behind only heart disease, cancer and stroke. A recent comprehensive study of medication errors estimated that as many as 2.7 million errors occur each year in American hospitals adversely affecting 130,000 patients. At least 28% of these errors were preventable, and nearly half of the errors were made in the prescribing process. Not only are these errors potentially dangerous to patients, they are extremely costly to the health care system, resulting in additional and unnecessary expenditures of as much as \$177 billion per year. Of this amount, seventy percent was attributed to unnecessary hospital admissions or prolonged hospital stays.

Currently 43 other states allow pharmacists to engage in collaborative drug therapy management protocols and agreements. Given the high cost associated with medication errors, this bill will result in significant savings in health care expenditures, including reducing Medicaid costs, Child Health Plus and Family Health Plus expenditures in New York.

Voluntary collaboration between physicians, nurse practitioners and pharmacists is successful in other states, accepted by the public and other members of the clinical team, measurable in terms of improved medication therapy outcomes, patient satisfaction and cost control. In skilled nursing facilities and hospitals,

this bill promotes greater efficiency in the health care delivery system and allows for the more efficient use of the physician's time for patients with more complex medical needs.

Today increasing numbers of pharmacists have specialized in certain disease areas such as asthma, diabetes, HIV/AIDS, and have developed medication compliance and disease management programs in community pharmacy settings. It is therefore entirely appropriate that the opportunity to collaborate with willing physicians be extended to include these sites as part of the demonstration program created in the bill.



Local Option Eliminate mandatory mail order pharmacy programs A.1267-A Colton/S.6007 Breslin SUPPORT

SUMMARY: The bill amends state insurance law by adding a new paragraph that states that no insurance policy that provides coverage for prescription drugs may require that the insured obtain the products from a mail-order pharmacy, nor may the policy impose a higher co-payment if the insured chooses to obtain prescription medications from a local retail pharmacy. The bill does not apply to prescription benefits provided through self-insurance such as unions, nor does it interfere with existing contracts negotiated through collective bargaining.

JUSTIFICATION: This legislation preserves freedom of choice for consumers. For local pharmacies, it restores parity with the mail order option. Studies document that a majority of consumers prefer the one-to-one relationship they have developed with a local pharmacist or pharmacy. Furthermore, patients are better served when their complete medication history is accessible to the dispensing pharmacist at the time prescription is filled so that a discussion about appropriate use, side-effects, allergies, possible therapy duplications and other issues can take place at the most clinically opportune time.

It is no secret that Pharmacy Benefit Managers (PBMs) aggressively move their clients into their mail-order pharmacy subsidiaries by either "prohibiting" consumers from getting their prescriptions filled at their community pharmacy or by imposing economic disincentives that effectively steer consumers there. These self-serving business practices have led to several well-documented court cases against PBMs.

Billions of dollars leave New York every year through mandatory mail order programs that have in fact proven to be more costly than programs with a local option or those that are exclusively based in community pharmacies. Passage of this legislation represents a step in the direction of keeping local independent pharmacies open and viable so that they can provide patient-centered one-on-one services that improve health, maintain independence and contribute to quality of life. Tax-paying, job-creating community pharmacies should no longer be disadvantaged by the heavy hand of mandatory mail order prescription programs. PBM's should no longer be allowed to drive prescription volume out of local pharmacies and into their own subsidiaries under the guise of "cost-containment."